

CRIBS FOR KIDS REFERRAL FORM

Once completed, this form can be saved and attached in an e-mail to Courtney.Rapone@state.de.us or printed and faxed to (302) 577-1129. If you make a referral by fax, please e-mail Courtney Rapone at the above address to confirm receipt. For questions or concerns please call (302) 255-1743. Your request will be processed within two business days. Thank you.

Referral Criteria: Check all that apply

- ☐ Baby is due within about six weeks
☐ Baby is less than twelve months of age
☐ Parents do not own an appropriate crib and are unable to purchase one
☐ Other, describe _____

Mother's Information

Name of mother/guardian: _____ Mother's DOB: _____

Mother's address: _____

Mother's e-mail: _____

Home phone: _____ Cell phone: _____

Other relevant maternal information (e.g. Spanish-speaking, drug abuse, monitored by DFS): _____

Race (check all that apply): ☐ Asian ☐ Black ☐ White ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Is there smoking in the home? ☐ Yes ☐ No. If yes, check: ☐ Mother ☐ Other: _____

Will baby be in daycare? ☐ Yes ☐ No

If Yes, check: ☐ relatives/friends ☐ center-based ☐ home-based

Mother's level of education: Last grade completed: _____ and currently in school? _____

Baby's name: _____ Baby's gender: ☐ Male ☐ Female

Baby's due date: _____ Baby's DOB: _____

Baby's Condition

- ☐ Full-term ☐ Healthy ☐ Health Issues ☐ Baby will be home on apnea monitor
☐ Other _____

Mothers Health Insurance: ☐ Medicaid ☐ Private ☐ None

If Medicaid, please specify: ☐ DCPI ☐ Unison ☐ DSP

MCI# if available: _____

Baby's Health Insurance: ☐ Medicaid ☐ Private ☐ None

If Medicaid, please specify: ☐ DCPI ☐ Unison ☐ DSP

MCI# if available: _____

Referring Agency Information

Date of Referral: _____ Referring Agency: _____

Referring Contract Person: _____

Phone number: _____ E-mail: _____

Other Referrals Made for Mother/Baby:

- ☐ DPH ☐ Smart Start ☐ DFS ☐ Other: _____

